DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Beneficiary Choices
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Health Plan Benefits Group

TO: All Medicare+Choice Organizations and Demonstrations, Cost Plans and PACE Organizations

FROM: Marla K. Kilbourne
Director
Division of Enrollment and Payment Operations

DATE: July 31, 2003

SUBJECT: Clarification of Procedures to Process Retroactive Elections--Action

The purpose of this letter is to provide you with the revised Standard Operating Procedures (SOP) used for processing retroactive adjustments of plan elections. This revised SOP is attached (Tab H dated July 28, 2003) and includes clarifying language on the submittal of certain election requests directly to the regional office.

Since May 1, 2003, requests for correcting Plan Elections (enrollments, disenrollments and Plan Benefit Package changes) for Medicare+Choice Organizations, M+C Demonstrations, and PACE Organizations have been sent to our retro processing contractor, IntegriGuard. However, some extenuating circumstances occur which may require you to appropriately send the request to your regional office. Language has been added to the top of page 3 of Tab H, Standard Operating Procedures For Retroactive Adjustment Of Plan Elections (dated July 28, 2003), to address these situations. This SOP replaces the May 2003 version.

If you have any questions regarding this letter, please contact Carol Eaton at 410-786-6165 or Ceaton@cms.hhs.gov, or your DEPO specialist.

Attachments

Tab H

STANDARD OPERATING PROCEDURES FOR RETROACTIVE ADJUSTMENT OF PLAN ELECTIONS
(Enrollments, Disenrollments And Plan Benefit Package (PBP) Changes)

This SOP applies to retroactive enrollments, disenrollments and Plan Benefit Package (PBP) changes involving all types of Medicare Managed Care Organizations (MCOs) and Demonstration project sites. This includes Cost Based Health Maintenance Organizations (HMOs), Health Care Prepayment Plans (HCPPs), Medicare+Choice Organizations (M+CO's), National PACE Organizations and Demonstrations as defined in their agreements with CMS. The SOP includes specific instructions for submission of these retroactive adjustments to the Payment Validation Contractor, IntegriGuard.

This SOP is provided only as a tool to assist in preparing retroactive enrollment and disenrollment cases for submission to IntegriGuard. Please refer to the Medicare Managed Care Manual or other appropriate CMS guidance resource for policy questions and additional details. These include Chapter 2 of the Medicare Managed Care Manual for the M+C program, and Chapters 17 and 18 for the Cost-based HMO's and HCPPs.

Guidelines for Requesting Retroactive Adjustments – Cost-Based HMOs and HCPPs

As a general rule, cost plans and HCPPs may not request retroactive adjustments. If a beneficiary should have been enrolled or disenrolled on a certain date and was not, the plan is reimbursed either by submitting a claim to fee-for-service Medicare, by an adjustment to their per member per month payment rate (based on a submitted budget request) or upon settlement of a cost report. However, in some limited cases, a cost plan can request a retroactive adjustment such as if it was caused by a CMS system error. This situation should be documented and immediately brought to the attention of the CMS Central Office, Division of Enrollment and Payment Operations. Should a cost plan require a retroactive enrollment or disenrollment, the request should be sent to CMS Central Office, Division of Enrollment and Payment Operations, with appropriate documentation (as described in this SOP)

Cost plans must retain original documentation supporting the request in their files.

If approved, an enrollment/disenrollment adjustment will be made retroactively to the statutory effective date, and payment adjustments will be made accordingly.

The cost plan should never submit duplicate information to Central Office unless specifically instructed to do so.

To follow up on specific previously submitted adjustments, a letter of inquiry should be sent separately from other adjustment requests. It should clearly state in the subject line that it is a follow-up to request(s) previously submitted. The letter must include the claim number of the individual, the contract #, the period involved and the date the original adjustment(s) was submitted.

Guidelines for Requesting Retroactive Adjustments – M+COs, M+C Demonstrations and PACE organizations

M+CO's must submit requests for adjustments within 45 days of receiving their monthly reports from CMS, to IntegriGuard in the format described below. You are to identify enrollment/disenrollment discrepancies during the monthly reconciliation of the Monthly Membership and Transaction Reply reports with your own records.

Prior to submitting requests to the Retro-Processing Contractor to retroactively adjust enrollment/disenrollment, the M+C Plan must complete the following actions:

- Ensure the beneficiary has proof of Medicare coverage
- Ensure that a completed/signed Election form, or a record of another allowable M+C election format, is on file (Note that Election forms are not required in the case of a PBP change that is classified as a passive election. Passive elections are where the beneficiary's choice requires no action taken.)
- Ensure that the date the beneficiary signed the Disenrollment Request or Election form precedes the effective date as necessary
- Ensure the reason for the retroactive enrollment, disenrollment or PBP change, is documented.

There are a variety of situations that may result in the need for a retroactive enrollment, disenrollment or change in PBP, included in Chapter 2 of Medicare Managed Care Manual. Some examples are:

- Beneficiary chooses to disenroll (but it was not acted upon—for example, a request is made to SSA who failed to process it in a timely manner)
- Beneficiary claims to have made a disenrollment request (and has not utilized Plan services).
- Lack of intent to enroll
- Lack of intent to enroll (medical condition)
- Move out of service area
- CMS Systems problems
- Multiple Transaction reject
- Not eligible for an MCO
  Not in HI master file/Not entitled to Part B
  Part B termination
- Employer Group Delays
- Erroneous Death
- Erroneous Cancellation

M+CO's must retain original documentation supporting the enrollment/disenrollment or change in PBP in their files.

Exceptions Requiring Submittal to the Regional Office

There may be a few extenuating circumstances when MCOs have an urgent need to request Regional Office intervention instead of sending an enrollment adjustment to IntegriGuard. These require immediate action regarding the enrollment or disenrollment of a beneficiary. Examples include:

- Items of congressional interest
- Requests that are time sensitive and where harm would be caused to the beneficiary such as a situation where immediate surgery or treatment is needed and the provider is refusing to serve the beneficiary until the provider is assured of payment from Fee-For-Service.
- Requests based on grievance decisions that are time sensitive.

The MCO should include the required documentation with the request and a cover letter explaining the need for immediate action. If the MCO has any doubt as to whether the request requires immediate RO intervention, the MCO should call the Regional Office to discuss the case. The ROs should make the determination whether or not the case warrants urgent processing. MCOs should not refer beneficiaries directly to the RO without discussing the matter with the appropriate RO contact. (Situations that are not specifically addressed in Chapter 2 are not considered extenuating circumstances and should be sent IntegriGuard in accordance with this SOP.)

Documentation Required to Retroactively Enroll, Disenroll or Change a PBP for a Beneficiary

Review Chapter 2 to ensure submittal of appropriate documentation for the action being requested.

MCO Contract Number (H#)

M+C Plans must submit a PBP# for all PBP changes and for enrollments on or after 6/1/2002. PBP#s are not required for disenrollments.

Beneficiary Name and Claim Number

Verification of enrollment, change in PBP, or disenrollment including starting/ending dates.

For retroactive enrollment (including PBP Changes) you must submit documentation supporting your case as appropriate. Multiple documents may be required to support your request. Acceptable examples of documentation include:

- Completed Election form or other election format including:
    - Date received by the MCO and welcome letter sent to beneficiary
    - Beneficiary signature and Application signature date.
    - Sex
    - Date of Birth
    - PBP Identifier (M+C Plans only)

    - Effective date of enrollment
    - Evidence of Part A and Part B coverage (examples are listed in Chapter 2 of the Medicare Managed Care Manual)
- Reason for retroactive enrollment
- Election form or other election record with corrected HIC number and documentation supporting the corrected HIC# such as a letter from SSA, or a copy of the Medicare card.
- Reinstatement for disenrollment based on member being out of service area, when it is determined that the member did not permanently move. Documentation that the member did not move must be provided.
- Copy of CMS reply listing showing that the MCO attempted to correctly enroll the beneficiary.
- Copy of the acknowledgement /acceptance letter sent to the beneficiary according to the time frames described in CMS policy guidance notifying the beneficiary that the Plans services are available as of the effective date.
- Copy of the CMS reply listing showing the erroneous termination due to death, or loss of Part A and/or Part B.
- Documentation from SSA which states that the beneficiary is living and SSA has corrected or is correcting the data to show the beneficiary is alive, or has never been shown as deceased.
- Letter from member showing that they wish to continue as a member of the MCO and the letter to the member advising them to continue using the MCO services.
- To correct erroneous enrollment rejections due to ESRD health Status,
    - Letter from a physician or dialysis facility that documents date of transplant or last month of dialysis, or states that the beneficiary did not have ESRD during the period requested.
    - Proof that the member was enrolled in the MCO prior to converting to Medicare status
    - Proof that the application was completed before the ESRD diagnosis. (A copy of the ESRD diagnosis signed by the physician and the beneficiary's signed and dated election form.)

- Completed enrollment election form or election format to change benefit plans including beneficiary signature and signature date, as appropriate.
- If an individual other than the beneficiary signs any documents for the beneficiary, documentation of power of attorney or other legal support must be provided.

<u>For retroactive disenrollment you must submit documentation supporting your case as appropriate. Multiple documents may be required to support your request. Acceptable examples of documentation include:</u>

- Death Certificate
- Completed, signed and dated form 566
- Original disenrollment request, signed and dated by the beneficiary, or other disenrollment election method allowed by CMS, showing date of receipt at the MCO.
- Retroactive disenrollment request signed by the member explaining either lack of intent to enroll or their alleged disenrollment date

- Claims for out of plan services during the month after the alleged disenrollment date
- Lack of primary care physician or MCO use
- Documentation that the beneficiary did not pay the plan premiums.
- Documentation that the beneficiary purchased a Medicare supplement
- Change of address records showing that the member has permanently moved out of the service area.
- Evidence in medical records of deteriorated mental comprehension dated prior to the election form signature date.
- A court decree of mental incompetence
- A letter from the member giving the date he/she moved out of the service area.
- Any other information that supports the request such as no record of utilization of plan services after the stated date of the move such as out of area claims, copy of the CMS reply listing showing move.
- CMS Reply listing showing the attempt to disenroll was made timely.

If the requested changes are approved, an enrollment/disenrollment adjustment will be made retroactively to the statutory effective date, and payment adjustments will be made accordingly.

To follow up on specific previously submitted adjustments, a letter of inquiry should be sent separately from other adjustment requests. It should clearly state in the subject line that it is a follow-up to request(s) previously submitted. The letter must include the claim number of the individual, the contract #, the PBP # (if appropriate), the period involved and the date the original adjustment(s) was submitted.

The M+CO should never submit duplicate information unless the Retro-Processing Contractor specifically requests the duplicate information be submitted.

Retro-Processing Contractor Review and Processing of the Request

The Retro-Processing Contractor will acknowledge receipt of the request for retroactive adjustments within 10 days of receipt. The Retro-Processing Contractor will process requested adjustments within 45 days of receipt, or return it to the MCO including the reason that the adjustment was not processed.

The Retro-Processing Contractor will validate the requested change and then enter the change in enrollment, change in PBP or disenrollment into MCCOY.

The Retro-Processing Contractor will return the request without action if the documentation is not complete and include the reason. The MCO may resubmit the request to the Retro-Processing Contractor including adequate and appropriate documentation.

The Retro-Processing Contractor will contact the appropriate Regional Office (RO) if the situation or documentation is not strictly addressed in Chapter 2 or Chapter 17 of the Medicare Managed Care Manual. If necessary, the RO will review the documentation and make a decision on the request, or contact the MCO to provide additional documentation to support the request.

When the action has been completed, it will appear on the MCO's Transaction Reply and Monthly Membership Reports.

The Retro-Processing contractor will provide a report to the MCO, which includes the action taken regarding each requested adjustment.

If an MCO disagrees with the decision of the Retro-Processing Contractor, they may immediately request that the RO review the documentation provided to the Retro-Processing Contractor along with a letter explaining the reason for the disagreement. The request must be received by the RO within 45 days of the retro-processing contractors response.

The MCO must submit the following documentation to the Regional Office to request a review of the Contractors' decision:

- A copy of the entire package the MCO submitted to the Retro-Processing Contractor
- A copy of the response from the Retro-Processing Contractor, including the disposition code
- An explanation of the reason that the MCO believes the Regional Office should reconsider the case.

IntegriGuard Requirements for Submitting Retroactive Enrollment, Plan Benefit Package Changes and Disenrollments

The M+COs will submit their requested adjustments to IntegriGuard. IntegriGuard will acknowledge receipt of the requested retroactive enrollment adjustment request within 10 days of receipt. This may be done via mail, e-mail or telephone. Requested retroactive enrollment adjustments will be processed within 45 days of receipt. Upon completion of processing, IntegriGuard will provide the M+CO with a report detailing the disposition of the requests, including an explanation of reasons for not entering the change as submitted into the system. Supporting documentation must be attached to the spreadsheet detailing the requested retroactive enrollment adjustments.

Enrollment, Disenrollment and Plan Benefit Package change requests are not eligible for the PROBE Studies. **Copies of supporting documentation as outlined in Chapter 2 of the Managed Care Guide and summarized in this SOP, must be included with the submission for each action requested.**

A spreadsheet that lists all requested changes included in each submission is required. The required information and specific column order needed to track each retroactive adjustment is as follows:

M+CO Name: **Contact Name:**
Mailing Address: **Phone #:**
City, State, Zip Code: **E-Mail Address:**

H#	PBP #	CMS Region #	Action Requested	HIC #	Beneficiary's Last Name	Beneficiary's First Name	Beginning Date mm/dd/yyyy	Ending Date mm/dd/yyyy

Please note:
All fields must be completed.

Action requested should be “enrollment” or “disenrollment”.

If there is no beginning date or ending date enter “N/A”.

The Plan Benefit Package (PBP) number is required for all requested retroactive enrollment adjustments after May 31, 2002. If the M+CO does not have the PBP number because the enrollment start date requested occurred prior to June 1, 2002 and does not extend into the PBP implementation timeframe of June 1, 2002, please place “N/A” in the PBP field. If the enrollment period does extend beyond the PBP implementation timeframe of June 1, 2002, a PBP number must be provided.

The PBP number is not necessary for disenrollments.

These requests may not be submitted electronically or by fax due to HIPPA.

Submission Addresses:

M+CO's, M+C Demonstrations and PACE

IntegriGuard
MMC Enrollment Project
Operations
10040 Regency Circle
Suite 260
Omaha, Nebraska 68114
Phone: 402-955-2781

Cost Plans

CMS
Div. of Enrollment and Payment

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7500 Security Boulevard
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